STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25842

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: RESACA ALLAMONG				2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 29, 1975	2b. HOUR: 5:30 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 12, 1892		6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.	
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	SYLVAN RETREAT

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
WILLIAM FURSTENBURG	MARY F. KELLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		213 74 1109	MARY JANE MULLEN LUTHERVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebrovasc. disease	
DUE TO, OR AS A CONSEQUENCE OF (b)	Old age.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4389

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/12, 19 75, to 11/29, 19 75, that (I) (we) last saw the deceased alive on 11/28/75, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	11/1/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. PETER HALMOS	MEMORIAL HOSPITAL CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/2/75	ROSE HILL CEMETERY	CUMBERLAND, MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	DEC 04 1975	[signature] ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15 (4))

75-25842

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25843

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Lindsey	MIDDLE: K	LAST: Arrington	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH: 11 DAY: 19 YEAR: 75	2b. HOUR: 12:50 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH 2 DAY 14 YEAR 23	6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 19 YEAR 75	2d. HOUR: 12:50 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: usa	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital--DOA	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Surplus Store			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Ridgeley	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 69 Knobley Street		
14. FATHER'S NAME: FIRST Thomas MIDDLE LAST Arrington	15. MOTHER'S MAIDEN NAME: FIRST Hattie MIDDLE M. LAST Shacklett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 229-26-1325	17. INFORMANT: Mrs. Daris Arrington	ADDRESS: Ridgeley, W.Va.	Wife		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ---
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).: Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X]; and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11-19-75

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. ADDRESS: R#9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11-21-75	23c. NAME OF CEMETERY OR CREMATORY: Warrenton Cemetery	23d. LOCATION CITY OR TOWN: Warrenton / COUNTY / STATE: Virginia	
24. FUNERAL DIRECTOR NAME: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR: DEC 01 1975	25b. REGISTRAR'S SIGNATURE: Frances Jean Martin ACTING REGISTRAR	

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

75-25813

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25844
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: RUSSELL — MIDDLE: D. — LAST: BEERY

2a. DATE OF DEATH — MONTH: NOVEMBER — DAY: 10, — YEAR: 1975

2b. HOUR: 6:30 P.M.

3. SEX: ~~Male~~ Male

4. RACE: White

5. DATE OF BIRTH — MONTH: Oct. — DAY: 10, — YEAR: 1907

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Salesman

12b. KIND OF BUSINESS OR INDUSTRY: Tea Company

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 1027 Penhurst St.

14. FATHER'S NAME — FIRST: John — MIDDLE: E. — LAST: Beery

15. MOTHER'S MAIDEN NAME — FIRST: Clara — MIDDLE: Haines — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

16b. (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Mrs. Jane Davis & Mrs. Jo Ann Evans Daughters

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease — 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/17/63, 19__, to 11/10/75, 19__, that I (we) last saw the deceased alive on 1/10/75, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: MD

ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/10/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. RICHARD WILLIAMS

22e. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-13-75

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION — CITY OR TOWN: Cumberland — COUNTY: Allegany — STATE: Md.

24. FUNERAL DIRECTOR — NAME AND ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. DATE REC'D. BY REGISTRAR: NOV 13 1975

25b. REGISTRAR'S SIGNATURE: Frances Jean Martin, ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16/25M
(VR A 15 (4)) 9/74

75-2584

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25845

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MARIE / E. / BENNA			2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 16, 1975	2b. HOUR A / 5:10 M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	July 11, 1912	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. / IF UNDER 1 YEAR MONTHS DAYS / IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES ☒ NO ☐	201 Industrial Blvd. East

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
John B. Martell	Elizabeth Plubell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mrs. Hilda Byers, Cumberland, Md. Daughter

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Bronchial pneumonia infection 1 day

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary ASCVD many years

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome & Short Bowel Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
June 75	Mesenteric Infarction	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from June 75, 19 75, to 16 Nov, 19 75, that (I) (we) last saw the deceased alive on 13 Nov, 19 75, and that (to the) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — Fred W. Miltenberger

22c. DATE SIGNED: 16 Nov 75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR.F.W. MILTENBERGER, MD.

22e. ADDRESS: 122 S.CENTRE STREET CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11-19-75	Shade Cemetery	Shade Township, Sommerset, Pa.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 19 1975	Thomas Jan Martben ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25845

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25846

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
RINA	NMI	BOUYER	NOVEMBER 24, 1975	5:52 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Apr. 3, 1917	58 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Italy	USA		ALLEGHANY COUNTY, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
La Vale Md	Allegany	La Vale	YES ☒ NO ☐	Stoneybrook Lane

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Thomas D'Alessio	Vincenza Maiello

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mr. William M. Bouyer, La Vale, Md. Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Carcinoma of ovary c metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 mos

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1830

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-16, 19 75, to 11-24, 19 75, that (I) (we) last saw the deceased alive on 11/23, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Andrew Stasko M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11-24-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. STASKO, M.D.	924 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11-26-1975	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME	108 VIRGINIA AVENUE CUMBERLAND, MD. 21502	NOV 28 1975	Thomas Jean Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

75-25846

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25847

1. DECEASED NAME (TYPE OR PRINT): FIRST CLARDEN MIDDLE AARON LAST BRIDGES

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 29 YEAR 75 — 2b. HOUR 5:13 PM

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 9 DAY 7 YEAR 07 — 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 29 YEAR 19 75 — 2d. HOUR 5:13 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital--DOA — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): B&O Railroad employee ret. — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Mt. Savage — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: R#1

14. FATHER'S NAME: FIRST Jacob MIDDLE LAST Bridges

15. MOTHER'S MAIDEN NAME: FIRST Frances MIDDLE LAST Blucker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-10-1255

17. INFORMANT ADDRESS: Mrs. Shirley Johnson, Rockford, Il

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 11-29-75

EXAMINER'S NAME (TYPE OR PRINT): BENEDICT SKITARELIC, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Dec. 5, 1975 — 23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Gardens — 23d. LOCATION CITY OR TOWN: La Vale — COUNTY: Co. Allegany — STATE: Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: Zeigler Funeral Home, Hyndman, Pennsylvania

25a. DATE REC'D BY REGISTRAR: DEC 11 1975 — 25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE MEDICAL EXAMINER, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25848

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JAMES	MCQUE	BRIDGES	NOVEMBER 21, 1975	2:00P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	WHITE	FEB. 16 1920	55 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PENNA.	USA		ALLEGANY CO. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HSOPITAL	MILL ROOM	KELLY TIRE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	LaVALE	YES ☐ NO X	ROUTE 1, BOX 111

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JAMES	C.	BRIDGES	MAUDE	DONAHOE	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW2	220 10 9061	MARGARET BRIDGES	LaVALE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Ca of the lung	
DUE TO, OR AS A CONSEQUENCE OF (b)	to Brain - liver.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-17-75, 19 75, to 11-21, 19 75, that (I) (we) last saw the deceased alive on 11-21 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J Mehanna	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11-21-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOHN N. MEHANNA M.D.	909A SETON DR., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	11/25/75	REST LAWN MEM. GAR.	CUMBERLAND, MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
KIGHT FUNERAL HOME	309 DECATUR ST. CUMBERLAND, MD. 21502	NOV 25 1975	Thomas Jan Matthews ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25849

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WILMA	IVA	BROADWATER	NOVEMBER 14, 1975	10:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
Female	White	April 7 1918	57 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED xx NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	USA		ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	House Wife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS
Md.	Garrett	Rural	xx	Rtl. Box 88

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	E.	Porter	Arvade		Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Joe E. Broadwater	Rt.1 Box 88 Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sarcomatosis - primary	18 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)	Neck	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1959

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Malnutrition

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
Dec 1954	Same	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from Dec, 19 74, to 14 Nov, 19 75, that I (we) last saw the deceased alive on 13 Nov, 19 75, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
F. W. Miltenberger	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	15 Nov 75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
F. W. MILTENBERGER, M.D.	122 SO. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov. 17, 1975	Mt. View Cemetery	Moscow Mills Alle. Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BOAL'S FUNERAL HOME	WESTERNPORT, MD.	NOV 18 1975	ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 1/75
(VR A 15(4))

75-25849

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 75-25850

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Ruth / V. / Browning
2a. DATE OF DEATH MONTH DAY YEAR	11 11 75
2b. HOUR	8:10 am
3. SEX	Female
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	1 15 1900
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS. HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany County MD.
10. CITY OR TOWN OF DEATH	Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Lions Manor Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Beauty Operator
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	913 National Hwy. LaVale
14. FATHER'S NAME FIRST / MIDDLE / LAST	James Oliver Stephen Hinkle
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Susan Virginia Willison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	219-03-9256
17. INFORMANT ADDRESS	Mr. Bevis Kerns, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio respiratory Arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinomatosis	months
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma of the breast	years

1747 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus ASC VD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/3, 19 75, to 11/11, 19 75, that (I) (we) last saw the deceased alive on 11/11, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Jane A. Fiscus M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED	11/11/75	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Jane A. Fiscus, MD	
22e. ADDRESS	Lions Manor Nursing Home, Cumberland, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 14, 1975	Restlawn Mem. Gardens	La Vale, Allegany Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	James F. Scarpelli, Cumberland, Md.	
25a. DATE REC'D. BY REGISTRAR	NOV 14 1975	
25b. REGISTRAR'S SIGNATURE	Marie Joan Martin ACTING REGISTRAR	

BP. 100

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO 75-25851

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 1660M 1/75
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	MARY MARGARET BUTLER	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 17, 1975
		2b. HOUR	10:00AM
3. SEX	FEMALE	4. RACE	WHITE
5. DATE OF BIRTH MONTH DAY YEAR	NOV. 15 1902	6. AGE (IN YEARS LAST BIRTHDAY)	73 YRS
IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY CO. MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HSOPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	SALESPERSON	12b. KIND OF BUSINESS OR INDUSTRY	DEPT. STORE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	ALLEGANY
13c. CITY OR TOWN	LA VALE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	SHORTEST DAY ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST	GEORGA LUCAS	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	MARGARET WALKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214 05 8304	17. INFORMANT ADDRESS	MRS. JANE SNYDER LA VALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma of The

DUE TO, OR AS A CONSEQUENCE OF (b) Thyroid Gland metastasis

DUE TO, OR AS A CONSEQUENCE OF (c) to The Lungs, Spine

193X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerosis CVD

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/26 19 75 to 11/17 19 75 that (I) (we) last saw the deceased alive on 11/17 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE (DEGREE) Adenocarcinoma MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 11/19/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.G. WEISMAN M.D.

22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	11/18/75	23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK
23d. LOCATION CITY OR TOWN	FROSTBURG	COUNTY	MD.	STATE
24. FUNERAL DIRECTOR NAME	KIGHT FUNERAL HOME	ADDRESS	309 DECATUR ST. CUMBERLAND, MD. 21502	
25a. DATE REC'D. BY REGISTRAR	NOV 21 1975	25b. REGISTRAR'S SIGNATURE	Thomas Joan Martin ACTING REGISTRAR	

BP

12-52821

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25852

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CHARLES WESLEY CHENOWITH			2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 19, 1975	2b. HOUR: 1:05 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 16, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.	
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Former Pipefitter	12b. KIND OF BUSINESS OR INDUSTRY: Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Florida	Palm Beach	Lantana	YES [X] NO [ ]	590 Mentone Rd.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Charles W. Chenowith	Sophia M. Thuss

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes, W. W. # 1	217-10-6242	James W. Chenowith, 345 Shady Lane, Palm Springs, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: One Month
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Malignant Melanoma
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1729

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/3, 19 75, to 11/19, 19 75, that (I) (we) last saw the deceased alive on 11/19, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Richard L. Snider MD	[X] / [ ] / [ ]	11/21/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. RICHARD L. SNIDER	MEMORIAL HOSP. MEDICAL BLDG. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/21/75	Sunset Memorial Park	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md. 21502	NOV 24 1975	Thomas Jon Matthew ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25853

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR	2b. HOUR
Anthony	--	Chucci	11-10-75 19	6:02 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	11-26-13	61 YRS.			11-10-75 19	6:02 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Oakmont, W. Va.	USA		Allegany MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	Memorial Hospital	Spinner	Textile

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS
W.Va.	Mineral	Keyser		102-B Street

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Michael	--	Chucci	Serafina	--	Poilucci

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	214-07-5610	Mrs. Anthony Chucci, Keyser, W.Va	102 B St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4109 Conditions, if ony, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) CORONARY OCCLUSION

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS -- / --

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-10-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS R#9, Cumberland, Md. 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 13, 1975	Queen's Point Cem.	Keyser Mineral W. Va.

24. FUNERAL DIRECTOR NAME / ADDRESS: Markwood Funeral Home, Keyser, West Virginia

25a. DATE REC'D. BY REGISTRAR: NOV 13 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

12-52823

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-25854

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN ☐ ESTIMATED ☒	MONTH	DAY	YEAR	2b. HOUR		
	GEORGE	A	COLEMAN			11	12	75	2 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR
Male	White	10	3	1916	59 YRS.						11-17-75 19	1 p.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing	Jackson Street	Construction	Work

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
MD	Allegany	Lonaconing	X	Jackson Street

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Anderson		Coleman	Isabelle	Johnson	~~Beeman~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	2nd W.W.	217-10-7139-A	Mrs. Fred Hughes	Lonaconing, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot of chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) (Self Inflicted)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

9557

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-17-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS R#9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	11/19/75	Laurel Hill Cemetery	Moscow	A	MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eichhorn Funeral Home, Lonaconing, Md.	NOV 21 1975	Thomas Jan Nastben ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME(5))
30M 7/73

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-25855

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH 17 20M 1/73
(VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST: Wilhelmina	MIDDLE: L	LAST: Connor	2a. DATE OF DEATH ESTIMATED: X	MONTH DAY YEAR: 11-21-75	2b HOUR: 6a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 5 1913	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 11-25-75 19	2d HOUR: 7a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 624 Maryland Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Employee	12b. KIND OF BUSINESS OR INDUSTRY: Tires			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES X NO ☐	13e STREET ADDRESS: 624 Maryland Avenue		
14. FATHER'S NAME FIRST: George	MIDDLE	LAST: Lease	15. MOTHER'S MAIDEN NAME FIRST: Harriett	MIDDLE	LAST: Troutman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-12-8394	17. INFORMANT: Charles Connor	ADDRESS: 624 Maryland Ave Cumberland, Md		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Coronary Occlusion, (Thrombosis) — Approximate interval between onset and death: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — -

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection X, Inquiry XX, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11-25-75

EXAMINER'S NAME (TYPE OR PRINT): BENEDICT SKITARELIC, M.D. ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Nov 28,75	23c. NAME OF CEMETERY OR CREMATORY: S.S.Peter & Paul Cemetery	23d. LOCATION CITY OR TOWN: Cumberland	COUNTY / STATE: Allegany Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Silcox-Merritt Funeral Service. 404 Decatur St Cumberland, Md	25a. DATE REC'D. BY REGISTRAR: NOV 28 1975	25b. REGISTRAR'S SIGNATURE: Thomas Jan Matthews DEPUTY REGISTRAR		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25856
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ELIZABETH Neel COOK	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 8, 1975	2b. HOUR	A 3:15 M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	Sept. 4, 1900
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Shepherdstown,	7b. CITIZEN OF WHAT COUNTRY?	W.Va. USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Own Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	W. Va.	13b. COUNTY	Mineral	13c. CITY OR TOWN	Keyser
13d. INSIDE CITY LIMITS? YES ☐ NO ☒		13e. STREET ADDRESS	Rt. 2 Keyser Along Reeses Mill Rd.		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Allen A. Payne Neel	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Ida -- Folk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	None	16b. SOCIAL SECURITY NO.	236-58-1117
17. INFORMANT ADDRESS	Mrs. Anne Kuykendall, Rt. 2 Box 232 Keyser, W.Va.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO, OR AS A CONSEQUENCE OF (b) A. S. Heart Disease — 10 years
DUE TO, OR AS A CONSEQUENCE OF (c) mitral valvulitis, rheumatic 45 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hyp. arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov 6 5, 19__, to 8 Nov., 19 75, that (I) (we) last saw the deceased alive on 7 Nov. 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	W. Alfred VanOrmer, M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 9 Nov. 75
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. W.A. VAN ORMER, MD.	22e. ADDRESS	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	11/10/75	23c. NAME OF CEMETERY OR CREMATORY	Elmwood Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Shepherdstown, W. Va.				
24. FUNERAL DIRECTOR NAME / ADDRESS	Harold W. McKnight W. Va. Mineral St. Keyser	25a. DATE REC'D. BY REGISTRAR	NOV 13 1975	25b. REGISTRAR'S SIGNATURE	Marie John Martin ACTING REGISTRAR

BP____

DHMH - 16 25M
(VR A 15 (4)) 9/74

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 8/75
(VR A 15 (4))

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25857

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: MELVIN	LAST: CUTTER	
2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 16, 1975	2b. HOUR: 8:05 AM		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 13, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Paper Mill	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: Allegany Street			
14. FATHER'S NAME FIRST: Unknown	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST: Barbara MIDDLE	LAST: Cutter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 216-09-6480	17. INFORMANT: Mrs. John Wilson "Daughter"	ADDRESS: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral metastasis & damage
DUE TO, OR AS A CONSEQUENCE OF (b): ca of the lung with metastasis
DUE TO, OR AS A CONSEQUENCE OF (c): COPD.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-3, 1975, to 11-16, 1975, that (I) (we) last saw the deceased alive on 11-16 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 11-17

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN N. MEHANNA, M.D.

22e. ADDRESS: 909-A SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/19/75	23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery	23d. LOCATION CITY OR TOWN: Lonaconing	COUNTY: A. STATE: Md
24. FUNERAL DIRECTOR NAME: EICHHORN FUNERAL HOME	ADDRESS: 8 E. MAIN ST. LONACONING, MD. 21539	25a. DATE REC'D. BY REGISTRAR: NOV 20 1975	25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR	

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25858
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ROLAND L. DOMAN

2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 20, 1975

2b. HOUR: 2:59PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: April 22, 1902

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WV.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b. KIND OF BUSINESS OR INDUSTRY: General

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: WV.

13b. COUNTY: Hardy

13c. CITY OR TOWN: Baker

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Rural

14. FATHER'S NAME FIRST MIDDLE LAST: Robert Doman

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Jennie McKee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES): No

16b. SOCIAL SECURITY NO.: 236-03-8815

17. INFORMANT ADDRESS: ✓ Fannye H. Doman Baker, WV. 26801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Parkinson's Disease
DUE TO, OR AS A CONSEQUENCE OF (c): Debility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4129
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov 20 19 75 to Nov 20 19 75, that (I) (we) last saw the deceased alive on Nov 20 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 11/20/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. TERRY WILLIAMS

22e. ADDRESS: MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11/23/75

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Baker Hardy WV.

24. FUNERAL DIRECTOR NAME ADDRESS: George K. Chambers Moorefield WV.

25a. DATE REC'D. BY REGISTRAR: NOV 24 1975

25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

12-52028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25859

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WALTER / EDWARD / EICHHORN, JR.	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 25, 1975
		2b. HOUR	7:25 AM
3. SEX	MALE	4. RACE	WHITE
5. DATE OF BIRTH MONTH DAY YEAR	JAN. 25, 1906	6. AGE (IN YEARS LAST BIRTHDAY)	69 YRS.
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY, MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	ALLEGANY
13c. CITY OR TOWN	FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET ADDRESS	416 PARK ST.		
14. FATHER'S NAME FIRST / MIDDLE / LAST	WALTER / EICHHORN	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	NELLIE / THORPE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	213-05-7129	17. INFORMANT ADDRESS	MRS. KATHLEEN EICHHORN, FROSTBURG MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis	
DUE TO, OR AS A CONSEQUENCE OF (b)	Decompensation	10 yr
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4299

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (1) (this hospital) attended the deceased from 11-9, 19 69, to 11-24, 19 75, that (I) (we) last saw the deceased alive on 11-25, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE (DEGREE) ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 11/26/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WAYNE C. SPIGGLE, M.D.

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV. 27, 75	JOHNSON CEMETERY	GARRETT COUNTY, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD. 21532

25a. DATE REC'D BY REGISTRAR: DEC 01 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jean Hartley, ACTING REGISTRAR

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 100

DHMH - 1660M 1/75
(VR A 15 (4))

75-25859

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25860

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
ELIZABETH	REITZ	FARRELL	NOVEMBER 29, 1975	9:35P M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	
FEMALE	WHITE	Sept. 6, 1903	72 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	USA		ALLEGANY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	OWN HOME			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	439 CUMBERLAND STREET

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ALEXANDER		REITZ	JENNY	ANDERSON	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215 26 9991	R. T. FARRELL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema	15 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Pericarditis	24 hr
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute Myocardial Infarction	24 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/5, 19 25, to 11/29, 19 25, that (I) (we) last saw the deceased alive on 11/29, 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J. A. Pagan	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/1/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. A. PAGAN M.D.	915 SETON DRIVE CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/2/75	ROSE HILL CEMETERY	CUMBERLAND, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
KIGHT FUNERAL HOME 309 DECATUR ST. CUMBERLAND, MD.	DEC 04 1975	ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25861

1. DECEASED NAME (TYPE OR PRINT)	FIRST JAMES	MIDDLE EDWARD	LAST FARRIS	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 27 1975	2b. HOUR 4:35A M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	March 12 1912	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer	12b. KIND OF BUSINESS OR INDUSTRY	Paper Mill
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Allegany	13c. CITY OR TOWN	Westernport	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS 260 Main St. Ext.
14. FATHER'S NAME FIRST	George	MIDDLE B.	LAST Farris	15. MOTHER'S MAIDEN NAME FIRST	Stella	MIDDLE F	LAST Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	236 03 2578	17. INFORMANT	Oda Farris	ADDRESS	Westernpoet, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4360 IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension — 20 yr.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE George Breza MD	DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED 11-28-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE M. BREZA M. D.	22e. ADDRESS 912 SETON DRIVE CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 30, 1975	23c. NAME OF CEMETERY OR CREMATORY Philos Cem.	23d. LOCATION CITY OR TOWN Westernport COUNTY Alle. STATE Md.
24. FUNERAL DIRECTOR NAME BOAL'S FUNERAL HOME ADDRESS WESTERNPORT, MD.	25a. DATE REC'D. BY REGISTRAR DEC 03 1975	25b. REGISTRAR'S SIGNATURE Thomas Jan Matthew ACTING REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 1/75
(VR A 15 (4))

75-25881

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25862

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARY	J.	FINZEL	NOVEMBER 21, 1975	1:42 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	WHITE	DEC. 30, 1897	77 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☐ NO ☐	

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	T.	ODEN	JENNY		CARTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		217-18-4796	JOHN FINZEL, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4369
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Augusto F. Figueroa	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	11/24/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. AUGUSTO FIGUEROA, MD.	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV. 24 '75	FINZEL CEMETERY	GARRETT COUNTY, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, FROSTBURG, MD.	NOV 28 1975	Thomas Jan Thurston ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25863

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ELVA	P.	FISCHER	NOV	7	75	10 45 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JUNE 20, 1894	81 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.	NEVER MARRIED	ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET & ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	FBG. COMMUNITY HOSPITAL	CLERK	DRESS SHOP

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	FROSTBURG	YES X NO	31 BEALLS LANE

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CHRISTIAN		FISCHER	ANNA	M.	HABERLEIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	213-01-5939	ELIZABETH FISCHER, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebro. Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Days

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES NO	YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/4, 19 75, to 11/7, 19 75, that (I) (we) last saw the deceased alive on 11/7, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Angel Roque M.D.	ATTENDING PHYSICIAN / MEDICAL DIRECTOR X / STAFF PHYSICIAN	11/8/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ANGEL ROQUE, M. D.	48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV. 10 '75	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, FROSTBURG, MD. 21532	NOV 12 1975	Frances Jean Matthew ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75 (VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25864

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST					2a. DATE OF DEATH	KNOWN ☒ ESTIMATED ☐	MONTH DAY YEAR	2b. HOUR
	Clara	Madelyn	Foor							11-4-75 19	5:30p M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR
Female	White	2-15-24	51 YRS.					11-4-75		19	5:30p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital--DOA	Housewife	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
W.Va.	Hampshire	Springfield	YES ☐ NO ☒	Rt. #6

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William		Crock	Lillian		Lewis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		219-14-6779	James C. Foor, Springfield, W,Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis, Right — Approximate interval between onset and death: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis, generalized — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Emphysema; Corpulmonale, marked

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-4-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	11/7/1975	Springfield Hill	Springfield	Hampshire	W,Va.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keith Shaffer	Shaffer Funeral Home Romney, W. Va.	NOV 12 1975	Diane Jan Matthews ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME(5))
30M 7/73

75-25884

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25865

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: MARGARET MARIE FOOTEN				2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 1, 1975	2b. HOUR: 4:30 a M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 10 1908		6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Silk Mill

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Allegany	Westernport	YES ☒ NO ☐	316 Hammond St.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
James Footen	Maggie Mayhew

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	232 01 1221	Neva Lupton	316 Hammond St. Westernport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Myeloma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
203X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure (2) Arrhythmia, Acardia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/24, 19 75, to 11/1, 19 75, that (I) (we) last saw the deceased alive on 10/31, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Felipa / Edwin, MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/1/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V. R. FELIPA, M.D.	907 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 4, 1975	Philos Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE OF REGISTRATION	25b. REGISTRAR'S SIGNATURE
BOAL'S FUNERAL HOME	11 CHURCH ST., WESTERNPORT, MD. 21562	NOV 6 1975	ACTING REGISTRAR

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25866
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
EDWARD	B.	GULBRONSON	NOV. 12 1975	1:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	May 30 1900	75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
Kifer, Md.	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND,	MEMORIAL HOSPITAL	Millright	Steel Mfg.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
W. Va.	Morgan	Paw Paw	YES [X] NO [ ]	c/o Postmaster	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Olaff		Gulbronson	Nettie		Hiett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		236-03-8122	Mrs Pansy V. Gulbronson Postmaster	Paw Paw, W. Va.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Disease 25411 — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b) —
DUE TO, OR AS A CONSEQUENCE OF (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
—	—		

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/2/75, 19—, to 11/12/75, 19—, that (I) (we) last saw the deceased alive on 11/12/75 19—; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
R. J. Williams	MD		11/14/75
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
DR. R. J. WILLIAMS	122 SOUTH CENTRE ST. CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	11/15/1975	Camp Hill	Paw Paw, (Morgan) W.Va.	
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Johnson Funeral Home Berkeley Spgs. W.Va.		NOV 18 1975	ACTING REGISTRAR	

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

Item 6 filmg490 12/8/75 cy

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25867

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
FRANCIS	A.	HARBAUGH	11	26	75	9:10A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	10	7	1887	~~87~~ 88 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U S A		ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSP. CUMB. MD.	RET, RAILROADER	RR

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	523 ESSEX PLACE. CUMB, MD.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
FRANK	L.	HARBAUGH	MARTHA	ELLEN	HICKEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	W W I		MMRS. ANN CECILIA HARBAUGH. CUMB, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis due to — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

185X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): prostatic adenocarcinoma — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease - senile - & heart disease, peripheral artery disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES / NO	YES / NO

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to 11/25/75, 19 75, that (I) (we) last saw the deceased alive on 11/25/75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	MD	X	11/26/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. WEISMAN	59 GREENE ST CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	11 - 29 - 1975	SS. PETER&PAUL	CUMBERLAND	ALLEGANY	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEASURE-STEIN FUNERAL HOME	230 BALTIMORE AVE CUMBERLAND, MD	DEC 02 1975	[signature] ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25868

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Almeda	MIDDLE: Heller	LAST	2a. DATE OF DEATH MONTH DAY YEAR: Nov. 22 1975	2b. HOUR: 4:55 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 21, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DOA Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 202 Virginia Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST: Edgar R. Smeltzer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Margery Mahaney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Mr. Earl R. Nixon, Cumberland, Md. Son		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4123 Coronary Artery Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/1/75 19__ to 11/22/75 19__, that (I) (we) last saw the deceased alive on 11/19/75 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: R. F. Williams, M.D.	ATTENDING PHYSICIAN ☒ *MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11/24/75	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Richard Williams MD	22e. ADDRESS: 122 S. Centre St., Cumberland, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Nov.25,1975	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR: DEC 01 1975	25b. REGISTRAR'S SIGNATURE: Grace Jan Martin ACTING REGISTRAR		

DHMH-16 60M-1-73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR — REG. NO. 75-25869

1. DECEASED NAME (TYPE OR PRINT): FIRST Earl; MIDDLE R.; LAST Holler

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 14 YEAR 19 75 — 2b. HOUR 3:40 P M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 12 DAY 30 YEAR 1922 — 6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 14 YEAR 19 75 — 2d. HOUR 3:40 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Maryland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital --DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cabinet maker — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Penna, — 13b. COUNTY: Bedford — 13c. CITY OR TOWN: Hyndman — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: Route #1

14. FATHER'S NAME: FIRST Robert; MIDDLE R.; LAST Holler — 15. MOTHER'S MAIDEN NAME: FIRST Nellie; MIDDLE M.; LAST DeVore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 190-16-1132 — 17. INFORMANT ADDRESS: Sacred Heart Hospital Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Rupture, left	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial Infarction	2-3 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Thrombosis	4-5 days

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE Benedict Skitarelic — TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER — DATE SIGNED 11-14-75

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. — ADDRESS Rt. #9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 11-17-1975 — 23c. NAME OF CEMETERY OR CREMATORY: Madley Cemetery — 23d. LOCATION CITY OR TOWN: R.D.#1 Buffalo Mills — COUNTY: Bedford — STATE: Pa.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Penna. — 25a. DATE REC'D. BY REGISTRAR: NOV 19 1975 — 25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY IN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25870

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17.20M 1/73 (VR A 15 ME (5))

1. DECEASED NAME (TYPE OR PRINT)	FIRST: William	MIDDLE: Benson	LAST: Jewell	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐	MONTH: Nov.	DAY: 9,	YEAR: 19 75	2b. HOUR: 11a M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH May DAY 27, YEAR 1886	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:	2c. DATE PRONOUNCED DEAD: Nov. 9, 19 75				2d. HOUR: 11:30 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.									
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 715 Maryland Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Test car driver	12b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland,	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS: 29 Massachusetts Ave.								
14. FATHER'S NAME: FIRST Emmanuel	MIDDLE J.	LAST Jewell	15. MOTHER'S MAIDEN NAME: FIRST Mary	MIDDLE E.	LAST Devers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No,	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-05-9576 A	17. INFORMANT ADDRESS: Mrs. Bette Reynolds, 29 Massachusetts Ave. Cumberland, Md.									

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes XX Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11/9/75

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M. D. ADDRESS Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/12/75	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION CITY OR TOWN Cumberland, COUNTY Allegany STATE Maryland
24. FUNERAL DIRECTOR NAME H. Wayne George ADDRESS 202 Greene St. Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR NOV 13 1975	25b. REGISTRAR'S SIGNATURE ACTING REGISTRAR

15-25870

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25871

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	THOMAS NMN JOHNSON	2a. DATE OF DEATH MONTH DAY YEAR	11/5/1975
		2b. HOUR	M
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	10/20/1893	6. AGE (IN YEARS LAST BIRTHDAY)	82 YRS.
IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Community Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired Miner	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD.	13b. COUNTY	Allegany
13c. CITY OR TOWN	Lonaconing	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS	Front Street		
14. FATHER'S NAME FIRST MIDDLE LAST	John Johnson	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Elizabeth Weir
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	Yes 1st. W.War	16b. SOCIAL SECURITY NO.	220-10-2357
17. INFORMANT ADDRESS	Edna Johnson Lonaconing, Md. (WIFE)		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive failure	10 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Sinus arrythmia	7 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	Years

4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Pneumonitis Chronic pul. fibrosis + Emphysema

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES [ ] NO [ ]		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]	
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from Nov. 4 19 75 to Nov. 5 19 75, that (I) (we) lost sight of the deceased alive on Nov. 4 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	[signature]	DEGREE	MD
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]		22c. DATE SIGNED	11.6.75
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	L.R. MILES, JR., M.D.	22e. ADDRESS	LONACONING MD 21539

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	11/8/1975	23c. NAME OF CEMETERY OR CREMATORY	Memorial Park
23d. LOCATION CITY OR TOWN	Frostburg	COUNTY	A	STATE	MD.
24. FUNERAL DIRECTOR NAME ADDRESS	Eichhorn Funeral Home Lonaconing, Md.	25a. DATE REC'D. BY REGISTRAR	NOV 10 1975	25b. REGISTRAR'S SIGNATURE	[signature] ACTING REGISTRAR

DHMH-16 60M 1/73
(VR A 15 (4))

75-25871

THOMAS HEN JOHNSON 11/5/1975

Male White 10/20/1893 82
X

MD. USA Allegany

Frostburg Community Hospital Retired Miner

MD. Allegany Lonaconing X Front Street

John Johnson Elizabeth Weir

Yes 1st. W.War 220-10-2357 Edna Johnson Lonaconing, Md.
(WIFE)

Burial 11/8/1975 Memorial Park Frostburg A MD.

Eichhorn Funeral Home Lonaconing, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25872

1. DECEASED NAME (TYPE OR PRINT): FIRST Leonard MIDDLE Elmer LAST Kasecamp

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ MONTH 11 DAY 19 YEAR 75 — 2b. HOUR 3:20p M

3. SEX: ~~Female~~ Male — 4. RACE: ~~White~~ White — 5. DATE OF BIRTH: MONTH 12 DAY 24 YEAR 12 — 6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 19 YEAR 75 — 2d. HOUR 3:20p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital--DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Custodian — 12b. KIND OF BUSINESS OR INDUSTRY: School

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: Jane Frazier Village

14. FATHER'S NAME: FIRST Denton MIDDLE Kasecamp LAST

15. MOTHER'S MAIDEN NAME: FIRST Nora MIDDLE House LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): W.W.II

16b. SOCIAL SECURITY NO.: 217-07-7855

17. INFORMANT ADDRESS: Anne Mae Kasecamp, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, LEFT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---
DUE TO, OR AS A CONSEQUENCE OF (c):

4109
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Cardiac Hypertrophy, marked

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 11-19-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. — ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 11/22/75 — 23c. NAME OF CEMETERY OR CREMATORY: Green Ridge Mtn. Cem. — 23d. LOCATION CITY OR TOWN COUNTY STATE: Allegany County, Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Philip B. Wendt 121 Memorial Ave., Cumb., Md.

25a. DATE REC'D. BY REGISTRAR: NOV 24 1975 — 25b. REGISTRAR'S SIGNATURE: Thomas Joan Matthews REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE AND EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25873

1. DECEASED NAME (TYPE OR PRINT): FIRST FREDA; MIDDLE GERARD; LAST KASTNER

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 11 YEAR 75 — 2b. HOUR 11:30 P.M.

3. SEX: FEMALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH 7 DAY 13 YEAR 1889 — 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 11-11-75 — 2d. HOUR 11:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA. — 7b. CITIZEN OF WHAT COUNTRY: U S A — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL-DOA — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE — 12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: W. VA. — 13b. COUNTY: MINERAL — 13c. CITY OR TOWN: SHORT GAP — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: RT #2 KEYSER W. VA

14. FATHER'S NAME: FIRST ISSAC MIDDLE LAST GERARD

15. MOTHER'S MAIDEN NAME: FIRST ESTELLA MIDDLE LAST PRINGLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: MRS. URSULA DODRILL. RT # 2 W. VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 11-11-75

EXAMINER'S NAME (TYPE OR PRINT): BENEDICT SKITARELIC, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 11-14-1975 — 23c. NAME OF CEMETERY OR CREMATORY: SS. PETER&PAUL CEM — 23d. LOCATION CITY OR TOWN: CUMBERLAND COUNTY: ALLEGANY STATE: MD.

24. FUNERAL DIRECTOR NAME: LEASURE-STEINFUNERAL HOME — ADDRESS: 230 BALTIMORE AVE CUMBERLAND, MD.

25a. DATE REC'D. BY REGISTRAR: NOV 18 1975 — 25b. REGISTRAR'S SIGNATURE: Thomas Jan Mathew ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M 1/73
(VR A15 ME (5))

75-25873

(M)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-25874

1. DECEASED NAME (TYPE OR PRINT): First Allen; Middle C.; Last Kessel

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month Nov. Day 24 Year 75

2b. HOUR 2:00 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month May Day 2, Year 1890

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. IF UNDER 1 YR. Months Days IF UNDER 24 HRS. Hours Min

2c. DATE PRONOUNCED DEAD: Month Nov. Day 24, Year 19 75

2d. HOUR 3:00 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY? U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland,

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prospect Dr. Fairgo

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer,

12b. KIND OF BUSINESS OR INDUSTRY: Celanese Silk

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland,

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Prospect Dr. Fairgo

14. FATHER'S NAME: First Felix; Middle S.; Last Kessel

15. MOTHER'S MAIDEN NAME: First Dora; Middle Belle; Last Shaffer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No, (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-07-3080 A

17. INFORMANT ADDRESS: Mrs. Wilma Ricewick, Box 11 Augusta, W. Va 26763

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Benedict Skitarelic — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 11/24/75

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. ADDRESS: Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11/28/75

23c. NAME OF CEMETERY OR CREMATORY: Kessel Cemetery

23d. LOCATION CITY OR TOWN: Kessel COUNTY: Hardy, STATE: W. Va.

24. FUNERAL DIRECTOR NAME: H. Wayne George ADDRESS: 202 Greene St. Cumberland, Md. 21502

25a. DATE REC'D. BY REGISTRAR: NOV 26 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25875

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 1/75 (VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Florence — MIDDLE: Lucille — LAST: Lepley

2a. DATE OF DEATH — MONTH: 11 — DAY: 28 — YEAR: 75

2b. HOUR: 10P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH: June — DAY: 19, — YEAR: 1913

6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — xxseparated

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany County MD.

10. CITY OR TOWN OF DEATH: Frostburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frostburg Community Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Companion for

12b. KIND OF BUSINESS OR INDUSTRY: elderly

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Penna — 13b. COUNTY: Somerset — 13c. CITY OR TOWN: Wellersburg — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS

14. FATHER'S NAME — FIRST: Eli W. — MIDDLE — LAST: Weimer

15. MOTHER'S MAIDEN NAME — FIRST: Linda — MIDDLE — LAST: Christner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-42-0776

17. INFORMANT — ADDRESS: Mrs. Emmabelle Murray, Corriganville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4369 IMMEDIATE CAUSE (a): Cardio-respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one day

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Vascular accident — 24 hours.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bilatinal Carcinma Breast. Poss. Carcinma Pancreas with malignant Ascites

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

X

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

X

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-4-75, 19__, to 11-27, 19 75, that (I) (we) last saw the deceased alive on 11. 27. 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S C Sandhir — DEGREE: M D — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/1/75

1

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. L. Sandhir, M.D., F.R.C.S.

22e. ADDRESS: 48 Tarn Terrace, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 1, 1975

23c. NAME OF CEMETERY OR CREMATORY: White Oaks Cemetery

23d. LOCATION — CITY OR TOWN: Meyersdale, RD, Pa. — COUNTY: Somerset Co. — STATE

24. FUNERAL DIRECTOR — NAME, ADDRESS: Harvey H. Zeigler, Hyndman, PA. 15545

25a. DATE REC'D. BY REGISTRAR: DEC 03 1975

25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25876

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR	2b. HOUR
John		Leptic	9-29-75 19	5 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	Mar. 18, 1914	61 YRS.			11-29-75 19	2 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Allegany County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	On mountain near Midlothian Md.	Stock Preparer	Tire Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Frostburg	YES ☐ NO ☒	Route 1

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas		Leptic	Katherine		Conrad

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. 2	213-09-9887	Mrs. Mary Leptic,	Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-29-75

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Dec. 2, 1975	Frostburg Memorial	Pk. Frostburg,	Alleg.	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Durst Funeral Home,	Frostburg, Md.	DEC 02 1975	ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-47
(VR A15 ME(5))
30M 7/73

75-25078

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25877

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	ETHEL V. LICHTY
2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 10, 1975
2b. HOUR	11:00 P.M.
3. SEX	F
4. RACE	W
5. DATE OF BIRTH MONTH DAY YEAR	May 23, 1907
6. AGE (IN YEARS LAST BIRTHDAY)	68 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany County MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Allegany
13c. CITY OR TOWN	LaVale
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	558 Braddock Ave.
14. FATHER'S NAME FIRST MIDDLE LAST	Marx Layman
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Rosa Cunningham
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	224-10-9152-D
17. INFORMANT ADDRESS	Memorial Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) CAD, ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2509
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov 10 75 to Dec 14 75, 19__, that (I) (we) last saw the deceased alive on Nov 10 75, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 11-11-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS

22e. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/14/75	Mt. Zion Cemetery	Frostburg, Garrett, Md.

24. FUNERAL DIRECTOR NAME Ruth Newman ADDRESS Grantsville, Md.

25a. DATE REC'D. BY REGISTRAR NOV 26 1975

25b. REGISTRAR'S SIGNATURE [signature] ACTING REGISTRAR

BP

DHMH - 1625M
(VR A 15 (4)) 9/74

75-25817

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25878

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) FIRST: THOMAS	MIDDLE: Mayo	LAST: LINTHICUM	2a. DATE OF DEATH MONTH DAY YEAR: 11 28 75
2b. HOUR: 12:55 PM	3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10/12/1887
6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSP. CUMB. MD.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Flintstone	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: Rt. #2, Box 22			
14. FATHER'S NAME FIRST: Thomas	MIDDLE: W.	LAST: Linthicum	15. MOTHER'S MAIDEN NAME FIRST: Sally MIDDLE: Jane LAST: Tolby
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW I	16b. SOCIAL SECURITY NO.: 220-36-8301	17. INFORMANT ADDRESS: Helen V. Linthicum, Flintstone, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 wks
DUE TO, OR AS A CONSEQUENCE OF (b): Adv. Arteriosclerosis — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H409

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4-6-3, 19 21, to 11-28, 19 21, that (I) (we) last saw the deceased alive on 11-27, 19 21, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/30/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. WILLIAM IAMES — 22e. ADDRESS: CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/30/75	23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Flintstone, Allegany, Md.
24. FUNERAL DIRECTOR NAME ADDRESS: Hafer Funeral Service, LaVale, Md.	25a. DATE REC'D. BY REGISTRAR: DEC 03 1975	25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR	

75-25818

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25879

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	EDGAR	MORELAND	MATTHEWS	
2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 26, 1975			2b. HOUR 11:45AM
3. SEX	Male			
4. RACE	White			
5. DATE OF BIRTH MONTH DAY YEAR	Nov. 30, 1895			
6. AGE (IN YEARS LAST BIRTHDAY)	80 YRS			IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH	Cumberland			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired			
12b. KIND OF BUSINESS OR INDUSTRY	Tire Ind.			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Allegany	Oldtown	YES ☐ NO ☒	Route 1

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William Matthews	Martha Moreland

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mr. Darrell Henry, Annapolis, Md. Nephew

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral infarction	1 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic CV Disease	10 yrs

4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic Heart Disease - Coronary occlusion & myocardial infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 73, to 11/25, 19 75, that (I) (we) last saw the deceased alive on 11/25, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
S G Weisman MD		11/26/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SG WEISMAN MD	59 GREENE ST CUMBERLAND MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 30, 1975	Sunset Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME 108 VIRGINIA AVE. CUMBERLAND, MD. 21502	DEC 04 1975	ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

75-25879

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25880

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Oscar	MIDDLE: Olin	LAST: May
2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ]	MONTH: 11	DAY: 21	YEAR: 75
2b. HOUR	4:20p		
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	MONTH: May	DAY: 4,	YEAR: 1919
6. AGE (IN YEARS LAST BIRTHDAY)	56 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:
IF UNDER 24 HRS. HOURS:	MIN.:		
7c. DATE PRONOUNCED DEAD	MONTH: 11	DAY: 21	YEAR: 75 19
7d. HOUR	4:20p		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]			
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.		
10. CITY OR TOWN OF DEATH	Cumberland		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Memorial Hospital---DOA		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Mechanic		
12b. KIND OF BUSINESS OR INDUSTRY	Self-Employed		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland		
13b. COUNTY	Allegany		
13c. CITY OR TOWN	~~Cumberland~~ Flintstone		
13d. INSIDE CITY LIMITS? YES [ ] NO [X]			
13e. STREET ADDRESS	Town Creek Road		
14. FATHER'S NAME	FIRST: Edward	MIDDLE: --	LAST: May
15. MOTHER'S MAIDEN NAME	FIRST: Nina	MIDDLE: --	LAST: Teeter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No,	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	212-18-1714		
17. INFORMANT ADDRESS	Edward A. May, Box #1261, Cumb. Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5718

Conditions, if ony, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Hemorrhage (esophageal varices) — 1 hour

DUE TO, OR AS A CONSEQUENCE OF (c) Portal cirrhosis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Emphysema, Marked

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [XX], Inquiry [XX], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-21-75

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 24, 1975	Glendale Cemetery	Flintstone, Allegany, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS	Wayne George, 202 Greene St. George Funeral Home, Cumberland, Maryland	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		NOV 26 1975	ACTING REGISTRAR

DHMH-47 (VR A15 ME (5)) 30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25881

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	CHARLES WILLIAM MC DERMOTT	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 21, 1975
2b. HOUR	3:15 PM		
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Oct. 3, 1888	6. AGE (IN YEARS LAST BIRTHDAY)	87 YRS.
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Registrar & Postmaster	12b. KIND OF BUSINESS OR INDUSTRY	Gov't
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland,	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET ADDRESS	235 Paca St. Queen City Towers		
14. FATHER'S NAME FIRST / MIDDLE / LAST	George W. McDermott	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Matilda -- Hines
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No,	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	220-28-9276	17. INFORMANT ADDRESS	Mrs. Elesta W. McDermott, 235 Paca St. Cumb. Md. 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated bowel
4369
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Peritonitis
DUE TO, OR AS A CONSEQUENCE OF (c) C.V.A
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-21, 19 75, to 11-21, 19 75, that (I) (we) last saw the deceased alive on 11-21, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE H Bahar DEGREE ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [✓]

22c. DATE SIGNED 11-23-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HADI BAHAR

22e. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	11/24/75	Hillcrest Burial Park,	Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS	H. Wayne George 202 Greene St. Cumberland, Md. 21502	25a. DATE REC'D. BY REGISTRAR	NOV 26 1975	25b. REGISTRAR'S SIGNATURE Frances Joan Martin

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25881

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15(4))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25882

1. DECEASED NAME (TYPE OR PRINT) FIRST: MAGGIE MIDDLE: A. LAST: MC DONALD	2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 26-1975	2b. HOUR: 2:00P M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH 8 DAY 13 YEAR 1886	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MAID- RET	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	537 N. CENTER ST. CUMB,MD.

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST JOHN MIDDLE J. LAST MIDDLETON	FIRST PERMEALIA MIDDLE LAST HARDEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		298-24-4105	MR. CHARLES YERGAN	RT #4 BOX 279B.CUMB,M

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): C-V-A. saddle embolism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): C-A-D

DUE TO, OR AS A CONSEQUENCE OF (c): Atrial fib.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-8 19 75 to 11-26 19 75 that (I) (we) last saw the deceased alive on 11-26 19 75 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Bahar DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑

22c. DATE SIGNED: 11-28-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. HADI BAHAR

22e. ADDRESS: MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	11-29-1975	TRINITY LUTHERAN, CEM.	CUMBERLAND ALLEGANY MD

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEASURE-STEIN FUNERAL HOME	230 BALTIMORE AVE. CUMBERLAND, MD	DEC 02 1975	Diane Jean Martin ACTING REGISTRAR

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25883

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
ELSIE	MAY	MC KENZIE	NOVEMBER 20, 1975	6:08 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
Female	White	11 3 1911	64 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland *****	U.S.A.		ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	SACRED HEART HOSPITAL	Housewife			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Allegany	Lonaconing	YES ☐ NO X	21 West Main Street

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert		Matthews	May		Gardner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
			Mr. Lawrence McKenzie	Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

792X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-15 19 25 to 11-20 19 25, that (I) (we) last saw the deceased alive on 11-20 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11-21-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WAYNE C. SPIGGLE M.D.	912 SETON DRIVE, CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	11/22/75	Sunset Memorial Park	Cumberland	A.	Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EICHHORN FUNERAL SERVICE	8 EAST MAIN ST. LONACONING, MD.	NOV 24 1975	ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 1660M 1/75 (VR A 15 (4))

75-25883

Female	White	11	3	1923	64
[illegible]	U.S.A.		x		
Cumberland					Housewife
Md	Allegany	Lonaconing		x	21 West Main Street
Robert	Matthews		May		Gardner

Mr. Lawrence McKenzie Lonaconing, Md.

Burial 11/22/75 Sunset Memorial Park Cumberland A. Md

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25884

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
GEORGE	EDWARD	MILLER	NOVEMBER 2, 1975	11:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.	
Male	White	Jan 13 1910	65 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		ALLEGANY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	SACRED HEART HOSPITAL		Retired Employee	Railroad	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Corrigansville	YES [ ] NO [X]	Mt Savage Road

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	E	Miller	Lottie	V	Roman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		#214-07-0550	Mrs. Bettie M. Miller	Mt Savage Road Corrigansville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma (R) lung - Lobe Sup — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/24, 1975, to 11/2, 1975, that (I) (we) last saw the deceased alive on 11/2, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
A. Sivan Pillai	M D	[ ] [X] [ ]	11/3/1975

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. SIVAN PILLAI M.D.	203 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov 5, 1975	Rest Lawn Mem Gardens	LaVlae Allegany Maryland

24. FUNERAL DIRECTOR NAME: STECOX MERRITT, FUNERAL HOME ADDRESS: 404 DECATUR ST. CUMBERLAND, MD.

25. DATE REC'D BY REGISTRAR: NOV 6 1975 REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 1660M 1/75 (VR A 15 (4))

75-25884

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25885

1. DECEASED NAME (TYPE OR PRINT): SAMUEL ~~GEORGE~~ GEORGE ~~SAMUEL~~ MYERS, SR.

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH 11 DAY 24 YEAR 19 75 — 2b. HOUR 9P M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 01 DAY 15 YEAR 14 — 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 24 YEAR 19 75 — 2d. HOUR 9P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA

8. MARITAL STATUS: MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: f Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER

12b. KIND OF BUSINESS OR INDUSTRY: CELANESE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Frostburg — 13d. INSIDE CITY LIMITS? YES [XX] NO [ ] — 13e. STREET ADDRESS: 126 Bowery Street

14. FATHER'S NAME: FIRST MAURICE MIDDLE LAST MYERS

15. MOTHER'S MAIDEN NAME: FIRST FLORENCE MIDDLE LAST WILSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): N.A.

16b. SOCIAL SECURITY NO.: 214-07-5342

17. INFORMANT ADDRESS: MRS. SAMUEL MYERS, 126 BOWERY ST., FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 17 Hours

955X Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): (Self-inflicted) — 11

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX], Inquiry [XX], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [XX], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 11-24-75

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 11/26/75 — 23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK — 23d. LOCATION CITY OR TOWN: FROSTBURG COUNTY: ALLEGANY STATE: MD.

24. FUNERAL DIRECTOR NAME: Harlan M. Sowers — ADDRESS: 60 W. MAIN ST. Hafer-Sowers, Frostburg, Maryland

25a. DATE REC'D. BY REGISTRAR: NOV 28 1975 — 25b. REGISTRAR'S SIGNATURE: Diane Jean Martin ACTING REGISTRAR

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

4 of 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25886

1. DECEASED NAME (TYPE OR PRINT): First: Milton; Middle: NMI; Last: Newton

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: Nov. Day: 1, Year: 19 75

2b. HOUR: 2:45 A.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Month: Dec. Day: 26, Year: 1900

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. IF UNDER 1 YR. Months: Days: IF UNDER 24 HRS. Hours: Min:

7c. DATE PRONOUNCED DEAD: Month: Nov. Day: 1, Year: 19 75

7d. HOUR: 2:45 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D. C.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland,

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Reg. Nurse, Ret.

12b. KIND OF BUSINESS OR INDUSTRY: Hospital

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland,

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 412 N. Mechanic St.

14. FATHER'S NAME: First: Jesse; Middle: --; Last: Newton

15. MOTHER'S MAIDEN NAME: First: Catherine; Middle: --; Last: Cox

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes, (IF YES, GIVE WAR OR DATES): W. W. # 1

16b. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Mrs. Frances Newton, 412 N. Mechanic St. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [XX], Inquiry [XX] and in my opinion death resulted from: Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11-1-75

EXAMINER'S NAME (TYPE OR PRINT): Benedict Skitarelic, M. D. ADDRESS: Rt. # 9 Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11/4/75

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.

23d. LOCATION CITY OR TOWN: Cumberland, COUNTY: Allegany STATE: Maryland

24. FUNERAL DIRECTOR NAME: H. Wayne George ADDRESS: 202 Greene St. Cumberland, Md. 21502

25a. DATE REC'D BY REGISTRAR: NOV 5 1975

25b. REGISTRAR'S SIGNATURE: [signature] STATE REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17-20M-1/73
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 75-25887

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: KINGSLEY GARDNER NICHOLS

2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 10, 1975

2b. HOUR: 12:40A M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: April 22,1902

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGHANY COUNTY MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Electrician

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: Kelly Road

14. FATHER'S NAME FIRST MIDDLE LAST: Arch Nichols

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Martha Gardner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Carl Nichols "Brother" N.Fort Meyers, Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ASHD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 yr

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): COPD — 15 yr.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GI Bleeding, Renal failure

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Breza MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11-10-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE M. BREZA, M.D.

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11/12/75

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Lonaconing A. Md

24. FUNERAL DIRECTOR NAME ADDRESS: EICHHORN FUNERAL SERVICE 8 EAST MAIN STREET LONACONING, MD. 21539

25b. DATE REC'D. BY REGISTRAR: NOV 13 1975

25c. REGISTRAR'S SIGNATURE: ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 132

DHMH - 16 60M 1/75
(VR A 15 (4))

75-25887

Male	White	April 22,1902	73	
Md	U.S.A.	x	ALLEGHANY COUNTY	
Cumberland	SACRED HEART HOSPITAL		Retired Electrician	
Md	Allegany Cumberland	x	Kelly Road	
Arch	Nichols	Martha	Gardner	
no		Carl Nichols "Brother"	N.Fort Meyers,Florida	

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-25888

1. DECEASED-NAME (Type or Print) First	Middle	Last
Meshach		Preston

2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ] Month: Nov. Day: 4 Year: 1975
2b. HOUR: 11:50 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	White	March 17,1899	76 YRS.		

2c. DATE PRONOUNCED DEAD Month: Nov. Day: 4 Year: 1975
2d. HOUR: 1:00 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Md.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Barton	Star Rt. Box 43	Coal Miner	Mining

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Barton	YES [ ] NO [X]	Star Rt. Box 43

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Preston	Amy		Metz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		216-09-2979	Lula Preston	B arton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	****
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: Nov. 4, 1975
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 7,1975	Potomac Valley Memorial Park	Keyser Mineral W.Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Beal Funeral Service	Westernport, Md.	NOV 10 1975	ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25889

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	EARL / BRADFORD / PURBAUGH	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 17, 1975	2b. HOUR	2:30P M
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR	DEC. 14, 1891
6. AGE (IN YEARS LAST BIRTHDAY)	83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	MINER
12b. KIND OF BUSINESS OR INDUSTRY	COAL MINES				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☐ NO ☐	

14. FATHER'S NAME FIRST / MIDDLE / LAST	HENRY / PURBAUGH	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	EMMA / HUTZELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	212-10-9137
17. INFORMANT ADDRESS	PATRICK PURBAUGH, FROSTBURG, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Weeks

DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure — Weeks

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 580X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Gangrene, Rt leg; Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/27, 19 75, to 11/17, 19 75, that (I) (we) last saw the deceased alive on 11/17 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE R. Espina, M.D. DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 11/18/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. ESPINA, M.D. — 22e. ADDRESS 907 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV. 20 '75	ST. PATRICK CEMETERY	MT. SAVAGE, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, 57 FROST AVENUE, FROSTBURG, MD.	NOV 24 1975	Thomas Jean Martin ACTING REGISTRAR

BP 160

DHMH - 1660M 1/75 (VR A 15(4))

75-25889

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25890

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH DAY YEAR	2b. HOUR
William	Casper	Reichert	11-25-75	10a M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	White	Aug 6 1886	89 YRS.			11-25-75 19	10a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Allegany MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital--DOA	Government	Inspector
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS
Maryland	Allegany	Cumberland		321 N. Centre Street
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John		Reichert	Tressa		Nehring
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		285-07-7245	Mrs. Anna M. Reichert	321 N. Centre St Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO X
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry XX and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-26-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov 28/75	Hillcrest Burial Park	Cumberland Allegany Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service.	404 Decatur St Cumberland, Md	NOV 28 1975	Irene Jean Martin ACTING REGISTRAR

75-25890

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-25891
REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST MILDRED MIDDLE E. LAST RINGER
2a. DATE OF DEATH	MONTH NOVEMBER DAY 11 YEAR 1975
2b. HOUR	4:25 P
3. SEX	Female
4. RACE	White
5. DATE OF BIRTH	MONTH Jan. DAY 30, YEAR 1907
6. AGE (IN YEARS LAST BIRTHDAY)	68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany County MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPES OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Penna.
13b. COUNTY	Bedfrod
13c. CITY OR TOWN	Hyndman
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	
14. FATHER'S NAME	FIRST Milton W. MIDDLE LAST Shaffer
15. MOTHER'S MAIDEN NAME	FIRST Stella MIDDLE Bradigan LAST Shaffer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
16b. (IF YES, GIVE WAR OR DATES)	
16c. SOCIAL SECURITY NO.	179 32 8222
17. INFORMANT ADDRESS	Wilbur G. Ringer Hyndman, Pa. 15545

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism
DUE TO, OR AS A CONSEQUENCE OF (c) Progressive CVA, ASCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☑	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital / I attended the deceased from Nov 11, 19 25, to Nov 11, 19 25, that (I) (we) last saw the deceased alive on Nov 11, 19 25, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 11-11-25

22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS

22e. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL	Burial
23b. DATE	Nov. 14, 1975
23c. NAME OF CEMETERY OR CREMATORY	Rockwood Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Rockwood, Somerset Co Pa.
24. FUNERAL DIRECTOR NAME / ADDRESS	Harvey H. Zeigler, Hyndman, Pa. 15545
25a. DATE REC'D. BY REGISTRAR	NOV 17 1975
25b. REGISTRAR'S SIGNATURE	[signature] ACTING REGISTRAR

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25891

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25892

1. DECEASED NAME (TYPE OR PRINT) FIRST: BESSIE	MIDDLE: M/	LAST: ROBERTSON	2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 13, 1975	2b. HOUR: 3:30PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 29, 1892	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES [X] NO [ ]	812 Calvin St.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William Dibert	Susan Dean

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no			Husband Mr. Carl M. Robertson, Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	10 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Heart Disease - Arteriosclerotic	Years
DUE TO, OR AS A CONSEQUENCE OF (c)	Cerebrovascular Disease	

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1961, 19__, to 11/13, 19 25, that (I) (we) last saw the deceased alive on 11/13/75 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G. Overton Himmelwright M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	11/15/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
G. OVERTON HIMMELWRIGHT, M.D.	133 VIRGINIA AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov. 16, 1975	Greenmount Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 19 1975	ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25892

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25893
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	STELLA B. ROLAND
2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 6, 1975
2b. HOUR	2:30PM
3. SEX	Female
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Feb 13 1899
6. AGE (IN YEARS LAST BIRTHDAY)	76 RS
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND,
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housekeeper
12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Flintstone	YES [ ] NO [X]	Route #1

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Eugene Rollins	Amanda Bennett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		216-38-1246	Charles R. Roland	Route #1 Flintstone, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/7/73, 19__, to 11/6/75, 19__, that (I) (we) last saw the deceased alive on 11/6/75, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
R. Williams	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	11/6/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. R. WILLIAMS	122 SOUTH CENTRE ST. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Nov 9,1975	Prosperity Cemetery	Prosperity Bedford Penna

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service.	404 Decatur St Cumberland, Md	NOV 10 1975	

BP

DHMH - 16 60M 7/73
(VR A 15(4))

12-52883

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25894

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	OCIE / LEE / SEARS	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 18, 1975
		2b. HOUR	A 5:15 M
3. SEX	Male	4. RACE	Caucasian
5. DATE OF BIRTH MONTH DAY YEAR	July 2, 1897	6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	West Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Bartender	12b. KIND OF BUSINESS OR INDUSTRY	Private Clubs
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	222 Harrison St.		
14. FATHER'S NAME FIRST / MIDDLE / LAST	William / -- / Sears	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mollie / -- / Flick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	W.W. #I
16b. SOCIAL SECURITY NO.	213-12-9076-A	17. INFORMANT ADDRESS	Mrs. Betty Lemaster, Rt.#3 Valley Rd. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septicemia

DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonitis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic brain syndrome; Chronic alcoholism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-12, 19 75, to 11-18, 19 75, that (I) (we) last saw the deceased alive on 11-18 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Robustiano J. Barrera M.D.	DEGREE	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	11-18-75		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. ROBUSTIANO BARRERA, MD.	22e. ADDRESS	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	Nov. 20, 1975
23c. NAME OF CEMETERY OR CREMATORY	Pleasant Grove Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE	Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME	H. Wayne George	ADDRESS	Cumb. Md. 202 Greene Street
25a. DATE REC'D. BY REGISTRAR	NOV 24 1975	25b. REGISTRAR'S SIGNATURE	ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH / 16 25M
(VR A 15 (4) 1 9/74

75-25894

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25895

1. DECEASED NAME (TYPE OR PRINT) FIRST CLARENCE MIDDLE SHEWBRIDGE LAST
2a. DATE OF DEATH MONTH NOVEMBER DAY 17 YEAR 1975
2b. HOUR 9:05PM
3. SEX Male
4. RACE White
5. DATE OF BIRTH MONTH Jan. DAY 15, YEAR 1925
6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrican
12b. KIND OF BUSINESS OR INDUSTRY Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland
13b. COUNTY Allegany
13c. CITY OR TOWN Cumberland
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS Route 4, Mexico Farms

14. FATHER'S NAME FIRST Clarence MIDDLE R. LAST Shewbridge
15. MOTHER'S MAIDEN NAME FIRST Rosalie MIDDLE Brehm LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WAr II
16b. SOCIAL SECURITY NO. 218-16-2710
17. INFORMANT ADDRESS Mrs. Erma Shewbridge, Cumberland, Md. Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) CAD + s/p MI
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) saw the deceased from Nov 17 19 75 to Nov 17 19 75, that (I) (we) last saw the deceased alive on 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE
DEGREE
ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED 11-18-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ~~WILLIAM P. JAMES~~ T.E. Williams
22e. ADDRESS ~~441 N. CENTRE ST.~~ Memorial medical bldg CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b. DATE 11-20-75
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery
23d. LOCATION CITY OR TOWN Cumberland, COUNTY Allegany, STATE Md.
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md.
25a. DATE REC'D. BY REGISTRAR NOV 20 1975
25b. REGISTRAR'S SIGNATURE Frances Jean Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 2M (VR A 15 (4)) 9/74

75-25895

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25896

1. DECEASED NAME (TYPE OR PRINT)	FIRST ROSETTA	MIDDLE ELIZABETH	LAST SHINGLER	2a. DATE OF DEATH MONTH NOVEMBER	DAY 30	YEAR 1975	2b. HOUR 3:00P M
3. SEX Female	4. RACE Caucasion	5. DATE OF BIRTH MONTH March	DAY 1	YEAR 1907	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Westernport	YES ☒ NO ☐	Rtl. #1 Westernport, Md.

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
James		Trenum	Bertha		Riggleman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		-------	J. Calvin Shingler	Rt. #1 Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular Tachycardia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension

DUE TO, OR AS A CONSEQUENCE OF (c) COPD

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-28, 1975, to 11-30, 1975, that (I) (we) last saw the deceased alive on 11-30 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	12-1-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL GLICK M.D.	915 SETON DRIVE CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 3, 1975	Queen's Point Cemetery	Keyser / Mineral / W.Va.

24. FUNERAL DIRECTOR (SIGNATURE)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BOAL'S FUNERAL HOME WESTERNPORT, MD.	DEC 05 1975	Shirley Jean Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

xx

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR 75-25897

REG. NO [redacted]

1. DECEASED NAME (TYPE OR PRINT) FIRST: BABY (Robert Leo) MIDDLE: BOY LAST: SHIRCLIFF

2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 17, 1975

2b. HOUR: 6:10AM

3. SEX: ~~Male~~ Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: November 16, 1975

6. AGE (IN YEARS LAST BIRTHDAY) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS 7 MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY CO, MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt #5 Box T.W.6

14. FATHER'S NAME FIRST: Raymond MIDDLE: E LAST: Shircliff

15. MOTHER'S MAIDEN NAME FIRST: Gloria MIDDLE: LAST: Bowles

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT: Raymond E. Shircliff ADDRESS: Route #5 Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Distress Syndrome — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Prematurity (2#7g) — 7 hrs
DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7762

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atelectasis left lung

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/16/75, 19____, to 11/17/75, 19____, that (I) (~~saw~~) last saw the deceased alive on 11/17/75, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph A Reiter, M.D.

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11/17/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RALPH A. REITER M.D.

22e. ADDRESS: 828 [redacted] Buckingham Rd., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Nov 17, 1975

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION CITY OR TOWN: Cumberland COUNTY: Allegany STATE: Maryland

24. FUNERAL DIRECTOR NAME: SILCOX, MERRITT FUNERAL HOME ADDRESS: 404 DECATUR ST. CUMBERLAND, MD. 21502

25a. DATE REC'D. BY REGISTRAR: NOV 18 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25898

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
ILLDA	J.	SHUCK	NOV. 8, 1975	11:15	AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JULY 21 1897	78 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		ALLEGANY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	OWN HOME		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	469 WILLIAMS STREET

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOSEPH		McKENZIE	ETTA		BEALL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		220 44 6410	OLIVE RICHARDSON	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Fracture of Hip

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
4 NOV 75	Fracture of hip	YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
		Fall at home

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Richard A. Johnson MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11/13/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. RICHARD JOHNSON	500 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/11/75	Mt. Pleasant Cem.	Cumberland, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Byron Kight	Cumberland, Md.	NOV 17 1975	Thomas Jean Matthews ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

Item 8 g494 4/28/76 gj

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 75-25899

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES	MIDDLE: M	LAST: SIRBAUGH	2a. DATE OF DEATH MONTH DAY YEAR: NOV. 4 1975	2b. HOUR: 10:05 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept 25 1900	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret, Railroader	12b. KIND OF BUSINESS OR INDUSTRY: B&O. RR		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 324 N. Waverly Terrace	
14. FATHER'S NAME FIRST: James	MIDDLE: R.	LAST: Sirbaugh	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Elizabeth	LAST: Carpenter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 168-10-4585	17. INFORMANT ADDRESS: Carol Lee Spiker. Cumberland, md.		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Septicemia secondary to staphylococcus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4823

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dehydration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-28, 19 25, to 11-4, 19 25, that (I) (we) lost saw the deceased alive on 11-4 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R J Barrera, Jr	DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11-6-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ROBUSTIANO J. BARRERA	22e. ADDRESS: MEM. MED. BLDG. CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11-7-1975	23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland-allegany- Md.	
24. FUNERAL DIRECTOR NAME: Leasure-Stein Funeral Home.	ADDRESS: 230 Baltimore Ave Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR: NOV 10 1975	25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin ACTING REGISTRAR	

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

75-25899

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-25900

1. DECEASED-NAME (Type or Print) First	Middle	Lost	2a. DATE KNOWN OF DEATH Month Doy Year	2b. HOUR
Keith	T.	Sisk	XX 11-5-75 19	6:30 a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Doy Year	2d. HOUR
Male	White	Jan. 3, 1915	60 YRS.					November 5, 1975	8am

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	1602 Frederick St.	Assistant Manager	Bowling Co.

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES X NO ☐	1602 Frederick St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Charles		Sisk	Amanda		Drake

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	214-07-0265	Mrs. Edna Sisk, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis, Left	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cardiac Hypertrophy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES X NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy XX Inspection X, Inquiry X, ond in my opinion deoth resulted from: Noturol couses X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED November 5, 1975

ADDRESS(Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 8, 1975	Sunset Memorial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William G. Kight Cumberland, Md.	NOV 10 1975	Thomas Jean Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 2 and 3 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 (Rev. 10M)
(VR ATSME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25901

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	HARRY E. SMITH
2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 24, 1975
2b. HOUR	8:12 AM
3. SEX	MALE
4. RACE	WHITE
5. DATE OF BIRTH MONTH DAY YEAR	SEPT. 21 1909
6. AGE (IN YEARS LAST BIRTHDAY)	66 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND,
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	MECHANIC
12b. KIND OF BUSINESS OR INDUSTRY	GAS COMPANY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	PENNA.
13b. COUNTY	BEDFORD
13c. CITY OR TOWN	BEDFORD
13d. INSIDE CITY LIMITS?	YES [ ] NO [X]
13e. STREET ADDRESS	ROUTE 3, box 235
14. FATHER'S NAME FIRST MIDDLE LAST	EDWARD SMITH
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	CORA WATERS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214 05 4409
17. INFORMANT ADDRESS	MARIE SMITH ROUTE 3, BEDFORD, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4/23 IMMEDIATE CAUSE (a) Severe Coronary Artery Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hospitalized

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis — for 22 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	—
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	—
20a. AUTOPSY?	YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	M Saheta — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED	11/29/75
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. P. HALMOS & SAHETA
22e. ADDRESS	MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
BURIAL	11/26/75	SUNSET MEM. PARK	CUMBERLAND, MD.	

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	DEC 02 1975	Thomas Jean Matthews ACTING REGISTRAR

BP 150

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25902

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	RICHARD C. SMITH
2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 7, 1975
2b. HOUR	2:15 PM
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	June 15, 1909
6. AGE (IN YEARS LAST BIRTHDAY)	66 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9 BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired Brick Mason-Construction
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	215 New Hampshire Ave.
14. FATHER'S NAME FIRST MIDDLE LAST	John Wm. Smith
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Cora Stephens
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS	Mrs. Dorothy Smith, Cumberland, Md. Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebrovascular accident	
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	THaelder MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐
22c. DATE SIGNED	11/9/75	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. THADDEUS ELDER ~~DR. TERRY WILLIAMS~~	
22e. ADDRESS	MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov. 10, 1975	Hillcrest Burial Park	Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME ADDRESS	James F. Scarpelli, Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE: Thomas John Hartlove ACTING REGISTRAR
		NOV 12 1975	

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

21502

RICHARD C. SMITH

NOVEMBER 7, 1975 2:15 P

CUMBERLAND, MD. MEMORIAL HOSPITAL

DR. THADDEUS ELDER

MEMORIAL MEDICAL BUILDING
CUMBERLAND, MD. 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25903

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
DOROTHY		SOMMERKAMP	NOVEMBER 23, 1975	10:35 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	March 31, 1914	61 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD	MEMORIAL HOSPITAL	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES ☒ NO ☐	1313 Virginia Ave.

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Joseph Niner	Blanche Page

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mr. Charles F. Sommerkamp, Cumberland, Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. TERRY WILLIAMS	MEMORIAL MEDICAL BLDG., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11-26-75	Restlawn Mem. Gardens	La Vale, Allegany, Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 28 1975	[signature] ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25903

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25904

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
James	Olin	Spiker	Nov. 23, 1975	10 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	3/22/1896	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Fbg. Community Hospital	Miner	Coal

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Allegany	Frostburg	YES [X] NO [ ]	254 Lower Consol Road

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		Spiker	Alice		Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW I	216-10-4519	Freda Spiker, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive Pulmonary Emboli	3 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Lung Disease - Black Lung	30 yrs.?
DUE TO, OR AS A CONSEQUENCE OF (c)	Advanced Arter. D. - Coronary Artery Heart Dis.	15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
Carcinoma of Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES [X] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-17, 1925, to 11-23, 1975, that (I) (we) last saw the deceased alive on 11-23, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Martin Rothstein	M.D.	[ ] [X] [ ]	11/24/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Martin Rothstein, M.D.	48 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/26/75	Johnson Cemetery	Frostburg, Garrett, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hafer Funeral Service, Frostburg, Md.	NOV 26 1975	Thomas Jan Marsh, ACTING REGISTRAR

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 60M 1-73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25905

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Olive	Mae	Spiker	Nov. 10 1975	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	Dec. 23 1901	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wales	U.S.A.		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Frostburg Community Hospital	HSWF	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Allegany	Lonaconing	YES ☒ NO ☐	11 Railroad St.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Stephen		Barnes	Miriam		Steele

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs. Miriam Daley	Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Renal Failure -	96 HRS.
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Advanced AHE V.D	10 yrs.?
DUE TO, OR AS A CONSEQUENCE OF (c)		

4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
NONE	✓	YES ☐ NO ☒	YES ☐ ✓ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
✓	✓	✓

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
✓	✓	✓

22a. I certify that (I) (this hospital) attended the deceased from 10-31 19 25, to 11-10 19 25, that (I) (we) last saw the deceased alive on 11-10 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Martin Rothstein	M.D.		11/11/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Martin M. Rothstein M.D.	48 Broadway - Frostburg, Md. 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/13/75	Sunset Memorial Park	Cumberland A. Md

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eichhorn Funeral Home Lonaconing, Md.	NOV 13 1975	Thomas Jan Matthews ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 1660M 1/75
(VR A 15 (4))

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-25906
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: VIRGIL D. STROSNIDER

2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 9. 1975

2b. HOUR: 7:56 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Jan. 4. 1911

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: Ballistics

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cresaptown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 13502 Nee Weaver Ave.

14. FATHER'S NAME FIRST MIDDLE LAST: William R. Strosnider

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Von Dorah Keckley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes

(IF YES, GIVE WAR OR DATES): War II

16b. SOCIAL SECURITY NO.: 236-20-9001

17. INFORMANT ADDRESS: Daughters Mrs. O'Nile Bean, Mrs. Anita Kaylor,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE: Memorial Hosp. Cumberland Allegany Md.

22a. I certify that (I) (this hospital) attended the deceased from 11-9-75 19____ to 11-9-75 19____, that (I) (we) last saw the deceased alive on 11-9-75 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: R. Williams M.D.

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11/10/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. RICHARD WILLIAMS

22e. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-12-75

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION CITY OR TOWN COUNTY STATE: Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR NAME ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. DATE REC'D. BY REGISTRAR: NOV 12 1975

25b. REGISTRAR'S SIGNATURE: Thomas Joan Mosher
ACTING REGISTRAR

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25900

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25907

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CHARLOTTE A. STUMP				2a. DATE OF DEATH MONTH DAY YEAR: NOV 11 1975	2b. HOUR: 8:25 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 21 1892	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U. S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Registered Nurse	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W, Va.	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Romney	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: River Road	
14. FATHER'S NAME FIRST / MIDDLE / LAST: James A. Stump			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Sally Hass		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 138-26-2389	17. INFORMANT ADDRESS: Geraldine C. Stump, Romney, West Virginia		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
485 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Congestive Heart failure due to arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-5, 19 25, to 11-11 19 25, that (I) (we) last saw the deceased alive on 11-11 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robustiano J. Barrera DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 11-16-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ROBUSTIA BARRERA 22e. ADDRESS: MEMORIAL MEDICAL BUILDING CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/13/75	23c. NAME OF CEMETERY OR CREMATORY: Stump Family Cemetery	23d. LOCATION CITY OR TOWN: Romney	COUNTY: Hampshire STATE: W, Va.
24. FUNERAL DIRECTOR NAME: Keith S. Shaffer ADDRESS: Shaffer Funeral Home, Romney, W, Va.		25a. DATE REC'D. BY REGISTRAR: NOV 20 1975	25b. REGISTRAR'S SIGNATURE: Thomas Jan Matthew ACTING REGISTRAR	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-25908

1. DECEASED NAME (TYPE OR PRINT): FIRST Vickie MIDDLE L LAST Swick

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 10 YEAR 19 75 — 2b. HOUR 1:52p M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: MONTH 10 DAY 18 YEAR 53 — 6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 10 YEAR 19 75 — 2d. HOUR 1:52p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W.Va. — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk — 12b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: W.Va. — 13b. COUNTY: Mineral — 13c. CITY OR TOWN: Ridgeley — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: Rt. #1

14. FATHER'S NAME: FIRST Ivan MIDDLE W. LAST Swick — 15. MOTHER'S MAIDEN NAME: FIRST Edna MIDDLE Carr LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. — 17. INFORMANT ADDRESS: Mr. Ivan W. Swick, Ridgeley, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Liver; Fractured Neck — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO, OR AS A CONSEQUENCE OF
(b): (Two car accident)
DUE TO, OR AS A CONSEQUENCE OF
(c):

8120
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 8:15 am 11-10-75 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in two car collision

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Rt. #51 — 21f. LOCATION STREET: Industrial Blvd & CITY OR TOWN: Cresap COUNTY: St. Mary STATE: Md.

22a. I certify that I took charge of the remains described above, held on Autopsy [X] Inspection [XX] Inquiry [XX] and in my opinion death resulted from: Natural causes [ ], Accident [XXX] Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 11-10-75

EXAMINER'S NAME (TYPE OR PRINT): BENEDICT SKITARELIC, M.D. — ADDRESS: R#9, Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Nov. 13, 1975 — 23c. NAME OF CEMETERY OR CREMATORY: South Branch Valley Mem. Park — 23d. LOCATION CITY OR TOWN: Petersburg, W. Va. COUNTY STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: Scarpelli Funeral Home, Cumberland, Md.

25a. DATE RECD. BY REGISTRAR: NOV 17 1975 — 25b. REGISTRAR'S SIGNATURE: Diane Jan Martin ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-17
(VR A15 ME (5))
30M 7/73

75-25908

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 75-25909

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR	2b. HOUR		
GEORGE	ROBERT	THORPE, SR.	11-20-75	4a M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	WHITE	JULY 2, 1929	46 YRS.			11-20-75 19	6a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.		ALLEGANY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
BORDEN MINES	DOA - RT. 2, BOX 304	CARPENTER	HOMES				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ALLEGANY	BORDEN MINES	YES ☐ NO ☒	RT. 2, BOX 304, FROSTBURG

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GEORGE	WILLIAM	THORPE	HELEN		FOLK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	KOREA	213-24-7438	MRS. G. ROBERT THORPE, SR., RT. 2, BOX 304	FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY THROMBOSIS, LEFT	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

CARDIAC HYPERTROPHY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 11-20-75

EXAMINER'S NAME (TYPE OR PRINT) Benedict Skitarelic, M.D. ADDRESS R#9, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	11/22/75	FROSTBURG MEM. PARK	FROSTBURG ALLEGANY MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	NOV 26 1975	Thomas Jan Matthew DEPUTY REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH 17
(VR A15 ME (5))
30M 7/73

x

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25910

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ELMER	G.	TWIGG	NOV. 3 1975	9:20A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	WHITE	NOV. 4 1903	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED-CUMBERLAND STEEL CO.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
CUMBERLAND MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	421 CENTRAL AVE.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
CHARLES	MARSHALL	TWIGG	DAISY	MAE	RICE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	~~WW II 1941-45~~	214-05-7774	BEULAH TWIGG 421 CENTRAL AVE CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary embolism	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Thrombophlebitis, right leg.	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

4510

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cor pulmonale, Pneumonia lobar.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-30, 19 25, to 11-3, 19 75, that (I) (we) last saw the deceased alive on 11-3, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robustiano J. Barrera	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	11-3-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. ROBUSTIANO J. BARRERA	MEM. MEDICAL BLDG. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	NOV 6 1975	SUNSET MEMORIAL PARK	CUMBERLAND ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT CUMBERLAND, MARYLAND	NOV 6 1975	Mary Jane Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25910

DR. ROBUSTIANO J. BARRERA REN. MEDICAL BLDG. CUMBERLAND, MD.

NOV 6 1975

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25911

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1660M 1/75
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT): FIRST ROBERT; MIDDLE ALEXANDER; LAST WEISE
2a. DATE OF DEATH: MONTH NOVEMBER; DAY 20; YEAR 1975
2b. HOUR: 8:30 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH July; DAY 23; YEAR 1909
6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY, MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Meat cutter
12b. KIND OF BUSINESS OR INDUSTRY: Meat packin
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Corriganville
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS
14. FATHER'S NAME: FIRST Calvin; MIDDLE L.; LAST Weise
15. MOTHER'S MAIDEN NAME: FIRST Emma; MIDDLE; LAST Spiker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-03-7609
17. INFORMANT ADDRESS: Mrs. Sherri Hoover, Meyersdale, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain metastasis.
1451
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Anaplastic ca of lobe
DUE TO, OR AS A CONSEQUENCE OF (c): G I Bleeding
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal failure

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-5, 19 75, to 11-20, 19 75, that (I) (we) last saw the deceased alive on 11-20, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: J. Mehanna
DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 11-21-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN N. MEHANNA, M.D.
22e. ADDRESS: 909A SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Nov. 23, 1975
23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetery
23d. LOCATION CITY OR TOWN: St. Paul; COUNTY: Somerset Co.; STATE: Pa.
24. FUNERAL DIRECTOR NAME: ZEIGLER FUNERAL HOME; ADDRESS: HYNDMAN, PA.
25a. DATE REC'D. BY REGISTRAR: NOV 26 1975
25b. REGISTRAR'S SIGNATURE: Marie Joan Matthew
ACTING REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-25912

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JAMES	EDWARD	WEISTER	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH / DAY / YEAR	11-29-75		2b. HOUR 10a M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH / DAY / YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH / DAY / YEAR	2d. HOUR
Male	White	3-11-36	39 YRS.			11-29-75	10a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Penna.	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Carpenter	Construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS
West Virginia	Jefferson	Shenandoah		Box 6

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Edward R. Weister		Ruby McCrew	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes		232 54 6951	Rose Basser (Wife) Shen. Jct. W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Shock, Hemorrhage	19 Hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Gunshot of Abdomen	19 Hours
DUE TO, OR AS A CONSEQUENCE OF (c)	(Accidental)	

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
11-28-75	Repair of abdominal organs due to gunshot	YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	9:30 a.m. 11-18-75	Accidental gunshot of abdomen	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	
	Rt.#50	Near Junction, W.Va. Jefferson, W.Va.	

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Benedict Skitarelic M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-29-75

EXAMINER'S NAME (TYPE OR PRINT) BENEDICT SKITARELIC, M.D. ADDRESS R#9, Cumberland, maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
burial	12/1/75	Pleasant View M. G.	Martinsburg, W. Va.	
24. FUNERAL DIRECTOR NAME AND ADDRESS	Melvin T. Strider, Ransom, West Virginia	25a. DATE REC'D. BY REGISTRAR	DEC 03 1975	25b. REGISTRAR'S SIGNATURE ACTING REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25913

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: REGINALD G. WELLS		2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 6, 1975	2b. HOUR: 6:30 PM
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH MONTH DAY YEAR: 6 - 29-1921	6. AGE (IN YEARS LAST BIRTHDAY): 54 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cumberland, Md.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Paper Hanger	12b. KIND OF BUSINESS OR INDUSTRY: Self

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES ☒ NO ☐	115 Independence, St. Cumb, Md.

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Will Wells	Eula Edwards	Yes WWII	213-18-2526	Howard W. Wells Cumberland, md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Alcoholic cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c): Alcoholism, chronic

3032

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-6, 19 75, to 11-6, 19 75, that (I) (we) last saw the deceased alive on 11-6 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Robustiano J. Barrera, Jr.	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	11-10-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. R. BARRERA	MEMORIAL MEDICAL BUILDING CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	11-10-1975	Woodlawn Cemetery	Cumberland Allegany Md

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Funeral Home. 230 Baltimore Ave. Cumberland, Md.	NOV 13 1975	Marie Jean Marchen ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-25914

1. DECEASED NAME (TYPE OR PRINT) FIRST: WILLIAM	MIDDLE: ZEDICK	LAST: WILT	2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 17, 1975	2b. HOUR: 3:00 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 2 1892	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ma ryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY CO. MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): La borer	12b. KIND OF BUSINESS OR INDUSTRY: Paper Mill		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Westernport	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: Rt. 1 Box 3 A	
14. FATHER'S NAME FIRST: Richard	MIDDLE	LAST: Wilt	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: L.	LAST: Wilt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WW1	16b. SOCIAL SECURITY NO.: 217 03 2171	17. INFORMANT: Alice Wilt	ADDRESS: Westernport, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage from — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours ?

DUE TO, OR AS A CONSEQUENCE OF (b): multiple ulcerations of the stomach (stress ulcers) — 24 hours ?

DUE TO, OR AS A CONSEQUENCE OF (c): multiple hemorrhages of ulcer Rupture of aneurysm of the aorta & hemorrhage into Psoas — 24 hours ?

4419

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease Coronary sclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/15 19 75 to 11/17 19 75, that (I) (we) last saw the deceased alive on 11/16 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/19/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S.G. WEISMAN M.D. — 22e. ADDRESS: 59 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Nov. 20, 1975	23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery	23d. LOCATION CITY OR TOWN: Westernport	COUNTY: Alle. STATE: Md.
24. FUNERAL DIRECTOR (NAME): BOAL'S FUNERAL HOME	ADDRESS: 11 CHURCH ST. WESTERNPORT, MD. 21562	25a. DATE REC'D. BY REGISTRAR: NOV 21 1975	25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

75-25014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-25915

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY MIDDLE M. LAST WOLFORD
2a. DATE OF DEATH: MONTH NOV. DAY 20, YEAR 1975
2b. HOUR 8:50A
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH FEBRUARY DAY 22, YEAR 1930
6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY: STATE COLLEGE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: FROSTBURG
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 412 PARK ST.

14. FATHER'S NAME: FIRST JOHN MIDDLE LAST CRIGER
15. MOTHER'S MAIDEN NAME: FIRST MARY MIDDLE E. LAST BLANK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-32-4741
17. INFORMANT ADDRESS: MR. IRVIN WOLFORD, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiogenic Cerebrovascular Syn
DUE TO, OR AS A CONSEQUENCE OF (c): CAD Cerebrovascular Syn
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks 2 yrs
180X
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a.I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 11/24/75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. L. LOUIS MOULD
22e. ADDRESS: 1068 NATL. HIGHWAY, LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: NOV. 22, 1975
23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICKS CEMETERY
23d. LOCATION CITY OR TOWN: MT. SAVAGE COUNTY: ALLEGANY STATE: MD.
24. FUNERAL DIRECTOR NAME AND ADDRESS: DURST FUNERAL HOME, FROSTBURG, MD. 21532
25a. DATE REC'D. BY REGISTRAR: NOV 28 1975
25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-25915

LARY M. WOLFORD NOV. 20,1975 8:50A

MALE WHITE MERCURY 22, 1930 45

MARYLAND U.S.A. X ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL STATE COLLEGE

MARYLAND ALLEGANY FROSTBURG X 412 PARK ST.

JOHN CHICEN NALY E. BLANK

NO 220-12-4741 MR. IRVIN WOLFORD, FROSTBURG, MD. 21532

X

DR. L. LOUIS MOULD 1068 NATL. HIGHWAY, LA VALE, MD.

BURIAL NOV. 22,1975 ST. PATRICKS CEMETERY MT. SAVAGE, ALLEGANY, MD.

DUNST FUNERAL HOME, FROSTBURG, MD. 21532